after operation. Besides, the new designed surgical gown is also suitable in the ward. Because the zippers were set from lateral side of bilateral sleeves opening along shoulder to collar, the patient could take off the surgical gown easily when there was an injection line in the patient's forearm.
Conclusion: The new designed surgical gown for patients is suitable for every kind of operations to expose adequate operative field without making the patient suffering from hypothermia and is easy to put on and take off when there is an injection line in the patient's forearm. The new surgical gown for patients may have the benefits for the patients and nurses in clinical care.

NDP110:
POSTULATED ALGORITHM FOR URINARY BLADDER DYSFUNCTION OF PATIENTS AFTER PELVIC MALIGNANCY TREATMENT – SHORT TERM REPORT OF A LOCAL HOSPITAL

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Purpose: The primary function of urinary bladder is for urine storage and voiding. Treatment for pelvic organ malignancy may deteriorate the originally normal bladder function. The aim of this study is to postulate a clinical steps for managing bladder dysfunction of the patients who had treatment for pelvic malignancy.
Materials and Methods: A retrospective chart review study was performed. From the urodynamic studies records, patients with pelvic organ malignancy after treatment (surgery or radiation) were enrolled. Patients' gender, age, causes of malignancy, were recorded and analyzed. Patients receiving urodynamic studies with benign causes were excluded. A possible flow chart to manage the bladder dysfunction was proposed by reviewing literature.
Results: From January 2014 to Marchl 2014, there were 77 patients eligible for urodynamic analysis. Pelvic organ malignancies included prostatic (31/77), bladder (18/77), colonic (21/77), and cervical (7/77) origin. The urodynamic studies were demonstrated by uroflowmetry and cystometry. In uroflowmetry (53 cases), maximal urine flow rate ranged from 6 to 17 ml/sec (mean 11.8). In cystometry (27 cases), most of the bladder contractility showed detrusor areflexia (11/27) followed by detrusor hyper-reflexia (7/27), hyper-reflexia (5/27) and normoreflexia (4/27). Several methods were postulated. Behavioral therapy, weight loss and pelvic muscle exercise, might improve neurogenic dysfunction. Medications consist of anti-muscarinic agents and newly developed B3-adrenergic agonist. Monotherapy or combined medications is based on the improvement of the patients. Side effects of B3-adrenergic agonist include hypertension, cardiac arrhythmia, and urinary retention. After refractory to prior management, invasive procedures including treatments with onabotulinumtoxin A botox, percutaneous tibial nerve stimulation, and sacral neuromodulation are available options.
Conclusion: This is a short term report. An algorithm will be drawn for clinical application. Further study for longer and larger scale is needed.

Renal transplantation

NDP111:
SUCCESSFUL REUSE OF A RENAL GRAFT 9 YEARS AFTER INITIAL TRANSPLANTATION – A CASE REPORT

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Purpose: Kidney transplantation is still the choice of renal replacement therapy for patients with end-stage renal disease (ESRD). However, shortage of organ is still the problem worldwide. In 1993, Amado et al. reported the first case of successful reuse of a transplanted kidney. After that, only few cases report were found at English literatures.
Herein, we report out experience of successful reuse of a renal graft 8 years after initial transplantation.
Case report: The first donor was a 40-year-old man with brain death due to intracranial hemorrhage after a traffic accident. The first recipient was a 45-year-old man and received transplantation in 2005. The immunosuppressant drugs were cyclosporine, everolimus, mycophenolate mofetil, and prednisolone.
In June 2014, the first recipient suffered from right cerebral aneurysm rupture and caused brain death. Serum creatinine level was 0.69 mg/dL. We harvested the transplanted kidney for reuse transplantation. The second recipient was a 40-year-old man who received hemodialysis for 5 years. The post-operative cause was uneventful and serum creatinine down to 1.17mg/dL.
Conclusion: Our case received refuse of transplanted kidney after 9 years after first transplantation. To our knowledge, this is probable the longest reuse of orange after first transplantation. In our experience, if the transplanted organ has good function, it could be still reuse years after transplantation.

Other

NDP112:
SUCCESSFUL ARTERIAL EMBOLIZATION FOR SPONTANEOUS ADRENAL HEMORRAHGE: A CASE REPORT

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Case report: A 53-year-old man denied any systemic disease visited ER due to sudden onset of severe right flank pain for half day. There was no past history of headache, palpitation, cold sweating, abdominal trauma, fever, nausea, vomiting, hematuria, or constipation. Physical examination found prominent tenderness over epigastric and right upper quadrant of abdomen and right costovertebral angle knocking pain. Tachycarida (117 beats/minute) and elevated blood pressure (164/89 mmHg) were noted. Complete blood count revealed leukocytosis (12900/Ul) without anemia (hemoglobin, 15.7 g/dL). Abdominal and pelvic computerized tomography with and without contrast was performed which showed 15*13 cm retroperitoneal hematoma in the right suprarenal region with a contrast extravasation and focal strong enhanced lesion about 3.5*2.4cm inside. Adrenal hemorrhage (AH) was suspected. Blood pressure drop (84/53 mmHg) with anemia (hemoglobin 10.3 g/dL) was noted 2 hours later. The blood pressure returned to 100/75 mmHg after fluid resuscitation and blood transfusion (2 bags of erythrocyte suspension). Emergent transcatheter arterial embolization (TAE) was performed 4 hours later and a branch of middle adrenal artery supplying the right adrenal lesion was identified and occluded with 3 metallic coil. The hemoglobin stabilized around 10 mg/dL and no more blood transfusion was given. The patient was discharged on post-TAE day 9 without sequelae. Adrenal study including plasma rennin activity, aldosterone, cortisol, and urine catecholamine and vanillylmandelic acid (VMA) were checked 4 months later and were normal. Follow-up abdominal CT revealed a 1.8 cm oval well-circumscribed heterogeneously low-density right adrenal mass with significant enhancement in a 4-month-interval CT and complete resolution of adrenal mss in a 26-month-interval CT.
Conclusion: Martin et al. analysed management of spontaneous AH associated with adrenal masses and found adrenalectomy was the major intervention in most cases (79%). Adrenalectomy followed TAE was 5% and treatment with TAE only accounted for only 2 %.
TAE can provides hemostasis and prevents emergent surgery which had been reported to increase postoperative mortality. Hokotate et al. reported a 82 % successful rate using TAE compared to over 90% successful rate using open or laparoscopic adrenalectomy for aldosteronoma. The successful rate in TAE for AH is still unknown, we presented a case with spontaneous AH treated by TAE successfully. In our case, we found only one branch of middle adrenal arteries supplying the adrenal mass. TAE can be used in hemorrhagic and hormone control of adrenal tumor. Pheochromocytoma was suspected during procedure of TAE due to transient elevated blood pressure. However, a 26-month-interval abdominal CT showed complete resolution of adrenal mass. In Martins et al. series, only 1 in 6 patient had complete resolution of mass after TAE and they concluded it was adrenal hematoma misidentified as adrenal tumor. The normal adrenal galnd found by follow-up CT scan attested this is a case of spontaneous AH treated successfully by TAE. This case highlights the importance of TAE for

AH which allows time for observation and prevents emergent or unnecssary surgery.

NDP113:
ADRENAL TRAUMATIC HEMATOMA MIMICS ADRENAL TUMOR: CASE REPORT AND REVIEW OF THE LITERATURE

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Case Report: A 67-years old woman presented to our outpatient department with a chief complaint of left adrenal tumor found after a traffic accident six months ago. There was no severe trauma in the traffic accident except multiple abrasion and contusion. She denied headache, palpitation, hypertension, sweating, or muscle weakness. There was no moon face, thin skin or buffalo hump. The lab data of VMA, aldosterone, renin, potassium and cortisol level were all within normal limit. The CT done after traffic accident revealed left adrenal mass 3.2 x 2.2cm with slight post-contrast enhancement. Non-functional adrenal incidentaloma was suspect and either surgical resection or follow up was suggested. The patient preferred follow up since there was no symptoms. The follow-up CT revealed gradually decreased size of left adrenal mass at 6 months and 12 months. CT at 48 months showed totally regression of left adrenal mass.
Conclusion: There are two most important questions about the evaluation and treatment decision making of adrenal incidentaloma: Is the tumor malignant? Is the tumor functional? If the tumor size is more than 4 cm, malignancy should be considered. In this situation, surgical resection should be considered. If the tumor is functional with symptoms, such as primary aldosteronism, Cushing's syndrome, or pheochromocytoma, surgical resection should also be considered. Otherswise, adrenal incidentaloma could be treated conservatively.
In this patient, the adrenal tumor was found in the CT after traffic accident. There were no associated symptoms and nonfunctional incidentaloma was suspect. After two-year follow up the adrenal tumor disappeared completely. Therefore, it was assumed as hematoma related to trauma. However, adrenal trauma is usually accompanied with other related organ injury and indicated major trauma. Isolated adrenal trauma is rare and could be confused with adrenal tumor easily. History taking and different diagnosis are important to avoid unnecessary surgery.

NDP114:
NEW APPLICATION OF THE URINE COLLECTION BAG CONTROL VALVE TWO CASE REPORTS

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This 69-year-old male patient has the history of DM with poor control. He suffered from scrotal swelling with pus formation for several days. He was sent to our emergency department for help. Fournier's gangrene was diagnosed and he received antibiotics treatment, several times of debridement and suprapubic cystostomy for the Fournier's gangrene. The patient's proximal to distal penile urethra and tunica albuginea of right corpora cavernosa were involved by the severe infection. Then the patient's urethra was closed in proximal penile urethra and the wound was closed layer by layer. The patient's wound healed well.
Due to the patient's daily activity was well, the urine collection bag connecting to cystostomy tube bothered him very much. So we used the urine control valve of the urine collection bag to connect with the cystostomy tube directly, then the patient could control the urine drainage from the urinary bladder by the urine control valve. The patient revealed that the urine control valve improved his daily life and social activity.
Another 58 y/o male patient suffered from difficult voiding for a long time. He received cystoscopy and distal penile urethral stricture was noted. He received dilation of urethra by sounding and 22 Fr. Silicone Foley tube was inserted for stenting of urethra.
Due to the patient worked at the traditional market, he didn't want to use the urine collecting bag. We used the urine control valve of the urine collection bag to connect the Foley tube directly. Then the patient could do his usual work without embarrassment. Besides, the urine control valve was also helpful in the patients suffering from acute urinary retention with the Foley tube indwelling.
Some commercial urine control valves have been developed. But these devices were expensive. The urine control valve was cheap. This new application of the urine collection bag control valve may be helpful for the patient with good daily activity needed for Foley tube indwelling.

NDP115:
UROSEPSIS LEADING TO FINGER GANGRENE: CASES REPORT AND LITERATURE REVIEW

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Purpose: Post-sepsis syndrome is a condition that affects up to 50% of sepsis survivors. They are left with physical and/or psychological long-term effects. For some patients, the cause of their PSS is obvious. Blood clots and poor blood circulation while they were ill may have caused gangrene and the need for amputations of fingers, toes, or limbs.
We would like to introduce a rare case of Urosepsis leading to finger gangrene in our hospital.
Case report: This is a 61 y/o female with history of DM and HTN. This time, the patient suffered from right flank pain for 2 days. The patient visited our GU OPD and right ureteral stone was suspected. The patient was transfered to our ER for further evaluation. At ER, malaise and low BP was found. Lab data showed pandemia and abdominal CT showed right lower third ureteral stone with hydronephrosis. Under the impression of urosepsis, the patient was admitted to SICU for further care.
Right PCN was done for decompression and infection control. However, agressive hemodynamic support with fluid replacement and high dosage of Levophed+Dopamin was need for keep vital stable. General condition stabilized gradually. However, right finger (finger1~finger4) gangrene change was noted, and we consult P.S Dr. Bokey, Pletaal, PGE1 and Infrared Radiation was suggested. Further amputation will be needed after gangrene margin became clear. However, sever leukocytosis (WBC >40000) was noted for days. Thus, we kept infection control first. Clinical condition got stable gradually. Operation with amputation was done after general condition got more stable.
Conclusion: Post-sepsis syndrome is a condition that affects up to 50% of sepsis survivors. They are left with physical and/or psychological long-term effects. The risk of having PSS is higher among people who were admitted to an intensive care unit (ICU) and for those who have been in the hospital for extended periods of time.
We would like to share our cases and compare with literatures published to give a whole picture of the disease in diagnosis, treatment and Prognosis.

NDP116:
ENDOUROLOGICAL MANAGEMENT OF IATROGENIC URETER INJURY AFTER ABDOMINAL AORTIC ANEURYSM SURGERY: REPORT OF 2 CASES AND LITERATURE REVIEW

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Purpose: Acute ureteral injury results from external trauma, open surgery, laparoscopy, and endoscopic procedures Urinoma, abscess, ureteral stricture, urinary fistula, and potential loss of an ipsilateral renal unit were complication of ureter injury. The incidence of ureteral injury varies between 0.5% and 10%. The iatrogenic cause were hysterectomy (54%), colorectal surgery (14%), other pelvic procedures like ovarian tumor removal (8%), transabdominal urethropexy (8%), and abdominal vascular surgery (6%). Endovascular stent grafts for the acute treatment was successful since 1996.